

water; in which proportions they unite at common temperatures; the wash to be snuffed up the nose frequently in the day. The odour was complained of as very disagreeable, and at the end of two days, he was disappointed by finding that no progress of improvement, in the appearance of the ulcers, had taken place. He now determined to apply the kreosote in its pure form, and began by pencilling the edges of the ulcers with a brush smeared with kreosote, and directing the patient to inhale the fumes of acetic acid for a few seconds subsequently. The application of the pencil was rendered easy by firmly grasping the ala nasi, and drawing it outwards; and he advised the inhalation of the fumes of acetic acid for two reasons: first, because acetic acid is the proper solvent of kreosote, and would, by being inhaled immediately after its application, have the effect of rendering its action more equable and uniform; and secondly, because the odour would tend to counteract the disagreeable fuliginous flavour of the kreosote. The next day he had the gratification to find the character of the ulcers improved; the edges were much less abrupt; and he then determined to apply the kreosote lightly over the whole of the ulcer on the left side of the septum, and to brush those on the right side with a solution of kreosote in twenty parts of acetic acid; and he continued to do so on alternate days for a week, at the end of which time, the ulcer on the left side of the septum was reduced to a mere point, having every appearance of immediately healing; whilst those on the right side, though improved in appearance, having smooth edges gently declining towards the centre, still preserved their original dimensions. He now applied to them also the pure kreosote, repeating the application on alternate days, accompanied with the inhalation of the fumes of acetic acid. The rapidity with which the ulcers now healed was truly wonderful. That on the left side, to which the kreosote in a pure state was first applied, was completely healed in ten days; and those on the right side, in six days after the first application of pure kreosote, and sixteen from commencement of treatment.

"From this case, it would appear, says Dr. S., that kreosote possesses the power of healing solutions of continuity in mucous membrane, and that with great rapidity, and in cases where all other treatment has proved unavailing. We also gather, that it is most to be relied upon, in its pure state, for the treatment of small breaches of continuity; although it possesses a decided action when dissolved in acetic acid, in the proportion of one part to twenty; but that the solution of one part in sixty of water, though preferable for use where the surface is large, was found quite useless in the instance before us.—*Dub. Journ.*, May 1837.

30. *Remedy for Ptyalism.*—KNOD and KLUGE assert that salivations, pains, swelling, and mercurial ulcerations are removed in the space of from four to six days by the following prescription: *R.* Iodini grs. v.; alcohol 5ij.; solve et adde, aq.; cinnam. ʒiiss.; syrup simp. ʒiiss. To be taken in the 24 hours in drachm doses.—*Gaz. des Hôp.*, July 18, 1837.

31. *Protiodide of Mercury in Psoriasis.*—M. POIRET recommends the following ointment to be rubbed in the morning and evening on the parts affected with the scaly eruption. *R.* hydrarg. protiodid. 5j.; axung. ʒj. The patient ought at the same time to take simple alkaline or vapour baths alternately.—*ib.* July 20.

SURGICAL PATHOLOGY AND OPERATIVE SURGERY.

32. *Introduction of air into the veins during operations.*—On the 4th of July, M. AMUSSAT communicated some observations to the Academy of Medicine of France on this subject, and detailed the method which he had found successful in preventing the fatal effects of its occurrence. He was operating, on the 1st of this month, on a woman aged 47, from whom a scirrhus affection of the right mammary gland, and subjacent and surrounding tissues, required to be removed. He had taken away all the right breast, and the adjacent parts implicated in the disease, and was tracing and cutting it away towards the opposite side, when suddenly, on making an incision into some suspected granulations on the inner side of, and below the left clavicle, he, and three other surgeons who were assisting him,

heard a sudden, distinct, interrupted sound, as of air passing into a cavity through a narrow opening. The patient immediately felt a sensation as of suffocation, and said she was dying. A second sound like the first, and following it at a brief interval, left the operator in no doubt of the nature of the accident, and he placed his finger on the spot from which the sound proceeded. The patient was more impressed with a sense of impending death than before; a cold sweat covered her face; her eyes were directed upwards; and all round her thought her dying. M. Amussat thought now of trying the effect of pressure on the chest to force out the air from the vein, whose orifice was uncovered. He accordingly compressed the whole chest very firmly several times, and then made an assistant press on the spot from which the sound had proceeded. After a few minutes the patient became much better, her anxiety diminished, and the operation being completed as soon as possible, a portion of the tissues around the situation of the open vein was tightly tied up with a ligature. The patient has gone on perfectly well since the operation, and there is every reason to anticipate her complete recovery.—*Gazette des Hôpitaux*, 6 July, 1837.

33. *Case of fall from a great height, with various injuries—followed by recovery.*—The following surprising case of fall the distance of 170 feet almost perpendicular, with recovery, is recorded by J. PATTERSON, Esq. in the *Edinburgh Med. and Surg. Journal* for January last. Private Thomas Gough, 42nd Royal Highlanders, aged 19½ years, on the 29th of August, whilst in a state of intoxication, attempted to escape from the castle of Edinburgh, in consequence of being refused leave to visit the city. For this purpose he chose the south side, and made his exit through a small embrasure overlooking the most precipitous and rugged face of the castle rock. His intention was, to jump upon a projecting ledge, from which he imagined he could scramble down the remaining part of the descent; but in doing so he broke his left leg; and in his own words, “stotted from rock to rock, till the road keppt him.” He fell the astonishing height of 170 feet almost perpendicular: and was found on the road immediately after his fall, quite insensible, and bleeding profusely.

He was instantly carried into the Castle, and on examination it was found he had received the following injuries; viz. three deep wounds on the head, in two of which the bone was exposed, and there was a fracture over the right frontal sinus;—the left clavicle was fractured about one inch from the sternal articulation;—the right wrist-joint was dislocated backwards, and both the radius and ulna of the same side were fractured;—there was an extensive bruised wound in the right ilium;—and the left tibia and fibula were fractured about two inches above the ankle-joint!

He was occasionally delirious for several days; but, with this exception, not a bad symptom appeared. He is now (2nd Oct.) nearly well, and there is every prospect of his resuming his military duties in a very short time.

Dec. 14.—The wrist-joint remained weak and enlarged for some time. He has now been discharged from the Hospital; and for a month has resumed all his duties as an efficient soldier.

34. *On excision of the smaller joints.*—By Dr. GERNET of Hamburg. Among the many improvements in modern surgery, the substitution of excision of diseased joints and of carious portion of bone for amputation of the limb, is not the least important. A considerable number of years have now elapsed since this principle was first applied to the treatment of caries of the larger joints, and, in a late number of the *Hamburg Journal*, we find Dr. Gernet, assistant surgeon of the Hamburg hospital, ably advocating its extension to the treatment of caries of several of the smaller joints. He reports seven cases, which were operated upon by Fricke, in the hospital. In four of these, the caries affected the bones of the hand, and, in the remaining three, those of the foot. Of the former number, the disease in three affected the metacarpal joint of the thumb, and was produced in one case by the point of an awl penetrating the joint; in the second, by the cut of an axe; and, in the third, it was ascribed by the patient to a wire, which, some months previously, he had drawn tightly round the thumb; but the chief cause seemed to lie in the cachectic state of the constitution. In the fourth case, the caries affected the metacarpal joint of the middle finger, and, as in one of the former instances, was caused by the wound of an awl.

In those cases in which the foot was the seat of the disease, the caries affected, in the first, the joint between the first and second phalanx of the great toe, and could not be ascribed to any evident cause; in the second, no caries existed, but a large exostosis, which was attached to the head of the first phalanx of the great toe, greatly incommoded the patient. In the third case, the caries affected the metatarsal joint of the great toe.

In all of these cases, the operation was performed by removing the extremities of both bones; and this was judged the more advisable proceeding, even in the case of exostosis, where no lesion of the opposite articular surface existed. The ends of the bone were then approximated as nearly as could be done without much difficulty or causing great uneasiness to the patient, and retained in this position by a peculiar apparatus. Union by the first intention was tried in two instances, but afterwards abandoned, and the wound was stuffed with charpie. Torsion was employed to arrest the hemorrhage from the mouths of bleeding vessels; a practice which seems to be followed in all operations in the Hamburg hospital.

It has been advanced against the operation of excision of the smaller joints, that the time required for the cure, and the length and pain of the operation, were more than equivalent for any advantage which could be derived from a shortened and ankylosed finger, and which perhaps would prove a worse than useless appendage to the patient. We shall therefore examine the results of the seven operations. Of the four cases in which the hand was affected, the success in three was complete. On an average, five and a half weeks were sufficient for the union of the wound and solidification of the bone; and all three were capable of returning to their work at the end of seven weeks. Two of them, in whom the metacarpal joint of the thumb had been affected, regained completely the use of the finger; and the other, the fourth case, was fast regaining the use of the finger when he left the hospital. In the third case, the wound healed slowly; but the patient was unable to use the thumb, and was dismissed at the end of three months, in rather an unsatisfactory state. Of the foot cases, the first was able to use the extremity at the end of five weeks; but, in the second, the cure was retarded by necrosis of a portion of bone till the end of the tenth week. Four weeks sufficed to effect the cure in the third.

In the first set of cases, the operation, including the time occupied in dressing the wound, lasted from fifteen to twenty-six minutes, the two extremes. In the second, ten, or at most fifteen, minutes were required. In no case were bad consequences, which could be ascribed to the nature of the operation, observed to follow.—*B. and F. Med. Rev. and Zeitschrift für die gesammte Medicin.* Band iii. heft 4. 1836.

35. *Remarkable fragility of the Bones.*—To the many extraordinary instances of fractures from the morbid fragility of the bones already upon record, we may add a curious case recently communicated to the University College Medical Society by Mr. Baker. A female 49 years of age, who had been for some years afflicted with scirrhus tumours in various parts of the body, was admitted into the North London Hospital for fracture of the left humerus, incident upon cutting a loaf of bread. A week after her admission she fractured her right humerus on raising herself in bed; she had previously broken the clavicle, in throwing a book out of bed, and had fractured her right humerus, (below the seat of the second fracture) whilst washing the face of one of her children. She subsequently fractured her left humerus in endeavouring to extinguish the flames of a child's dress which had caught fire. A patient of Mr. Liston's fractured her femur, by standing on one leg, and shortly afterwards fractured her arm by throwing it over the edge of the splint. In these cases the callus was abundant and the fractures readily united.—*Lancet*, Ap. 8, 1837.

36. *Excision of a portion of the spleen.*—This operation has been performed by Dr. MACDONALD, as we learn from a recent No. of the *India Journal of Medicine*, on a native about 30 years of age, who was gored in the abdomen by a buffalo. Through the wound, which was about three inches in length, a portion of spleen protruded. Six days afterwards the patient sought the advice of Dr. M., who removed the protruded portion of the spleen with the knife. Recovery was rapid. Another instance in which a portion of spleen was excited by Dr. W. B. Powell, will be found recorded in our No. for Feb. 1828.

37. *Clinical Observations on opening Abscesses*, delivered at La Pitié. By M. LISFRANC.—If you consult those books which treat of abscess, you will find it laid down as a general rule, that where the abscess is of small size, it ought to be left to nature to effect an opening, because this, it is said, will be small, and consequently leave but an inconsiderable cicatrix. According to this view, small abscesses are to be left to themselves, provided they be not too indolent, and do not advance too rapidly. But I reject this method; for if the aperture made by nature be small, why should not that made by art be made small likewise? It is only necessary for this purpose that we use an instrument with a narrow blade, and that we make a simple puncture.

Again, before opening an abscess, it has been thought that we must wait till the matter be well formed, or in other words, till the abscess be ripe, although to this some exceptions have been made, as with regard to abscesses in the abdominal and thoracic parietes, and those situated in the neighbourhood of tendons and joints. I have opened such abscesses before they were well formed, and what has happened? As long as I confined myself to the method recommended in books, I did not reach the root of the malady. Convinced of its insufficiency, I attempted to combat the inflammation excited by the pressure of the pus on the surrounding soft parts, by fomentations and local bleeding. Immediately after opening the abscess, I applied leeches, which were more efficacious in proportion as the swelling was recent.

This first satisfactory result soon led me to another; sometimes the leeches partly failed, and the induration passed into a chronic state. In conformity with the principles which I laid down in treating of white swelling, I allowed this state to remain undisturbed three or four days, after which I successfully attacked it by means of frictions with ointment of hydriodate of potass and ioduret of lead, as well as by compression, when necessary.

One objection only remains to be refuted—that of the pain, which was supposed to be greater in this than in the ordinary method. It is true that the pain of the incision is a little more acute when an abscess is thus prematurely opened, but it only continues a few moments, and accordingly I hold that abscesses ought to be opened as soon as the existence of pus can be detected. I have followed this practice for fifteen years, and I need not remind you that you have yourselves been witnesses of its success.

If you have to open an abscess of small size, as for instance that of an egg, and if the skin be thinner at the centre than any where else, you must make your opening there for two reasons; first, because the integuments being thinner, the instrument passes through a smaller extent of integument, and consequently gives less pain, and also because the incision gives to the integuments a slight degree of stimulus which facilitates their cicatrization: it is also very easy to prevent the pus from stagnating in the abscess by making pressure on its parietes. For larger abscesses it has become an established rule to open them at the most dependent part, unless there be some important blood-vessel or nerve in that situation.

If, in order to arrive at the abscess, you have to pass through a muscle, the incision ought to be made in a direction perpendicular to the action of its fibres—that is to say, that when the muscle is broad, you must cut across; but if, on the contrary, it be narrow, your incision must be parallel to the fibres, to avoid the risk of dividing it altogether. If in the case of a broad muscle, such as I first supposed, your incision were parallel to the fibres, it would almost always happen that the aperture would be completely closed by their contraction. You have lately witnessed a remarkable case, which I may quote here. A patient, in the ward of St. Louis, had a large tumour on the thigh, which not only afforded the ordinary signs of fluctuation, but evinced a distinct gurgling. I practised an incision parallel to the axis of the thigh, at the most dependent part: nothing was evacuated. I introduced a hollow sound into the wound, but still nothing came out. I then made another incision, at a point where the fluctuation was still more evident, but with the same negative result. The patient was very nervous, and his muscles contracted with force. Astonished at the circumstance, I next introduced a grooved sound along the blade of the bistoury, which yet remained in the wound; but still no pus made its appearance. My next proceeding was to make a movement with the two instruments, in such a manner as to separate

them and prevent the contractile action of the muscular fibres: then, at length, the pus found an exit. I request your attention to this point, which is a very important one, for I am persuaded that it happens very often, particularly when the fluctuation is not very evident, that the surgeon, after having made his incision, erroneously supposes there is no pus, merely because the opening having been made parallel to the direction of the muscular fibres, their contraction again closes up the aperture.

Abscesses of the neck ought to be opened by means of a simple puncture. I do not now allude merely to small abscesses: I have opened, in this manner, purulent depôts of considerable size, and, although the extent of the incision was not in proportion to the collection of matter, yet was all the pus evacuated, while the cicatrix which remained did not exceed that of a leech bite. This precept is of great importance, not only to the welfare of the patient, but to the reputation of the surgeon, and, in this double view, merits your attention. The following is an illustration in point:—I was called, three years ago, to Belleville, to open an abscess on the neck of a young lady, which I effected in the manner above recommended. In the same house was a child, having an abscess similar to the other in situation and nature. A practitioner there opened it by an incision of an inch in length, and had reason to repent of having done so; for the comparison of the two children, after the healing of the wounds, was very disadvantageous to him; the wound in his patient having healed slowly, and left a large cicatrix.

In abscesses of the neck, owing to the smallness of the aperture, the want of freedom with which the pus flows, and its remaining about the cellular tissue, there may be a little lodgment at the lower part, forming a kind of *cul de sac*, whence compression is insufficient entirely to dislodge the matter. In such case it is necessary to make a small counter opening, cutting upon the grooved canula, so as to make a second incision, no larger than the first, and thus the two look like leech-bites. The same precepts apply to those parts generally which are habitually exposed. In the neck, as on the forehead, the incision ought to be transverse,—that is, in the direction which the folds of the skin naturally assume in those situations.

In those parts, however, where the appearance of the cicatrix is not an object, modern surgeons make incisions of several inches where the abscess is large; and experience has proved the advantage of this practice. The bistoury is to be held in the first position: the two last fingers, separated from each other, and extended, are to be placed, if possible, beyond the tumour, as a *point d'appui*: the tissues which are penetrated must be divided in a perpendicular direction: the middle finger, placed on the blade of the instrument, serves to regulate the depth of the incision. This is very important, for if the instrument cuts ill, or if the texture be hard, we are under the necessity of pressing more strongly on the parts to be divided; and without the precaution of having the finger as I have described, we should incur the risk of plunging in the instrument too far. Besides, it is easy to push the bistoury farther in if necessary, by drawing back the finger on the blade of the instrument. We must do all gently: thus, when the blade arrives in the collection of pus, the hand will perceive the fact, because the knife is now passing through a less resistance than before. The only exception to this is where there are muscular contractions of a nature to interfere with the resistance. I cannot well give you a measure of the slowness necessary in this proceeding; but always remember this fundamental principle in operative surgery—*tutè* is better than *cito*.

I have advised you to make the instrument penetrate the integuments perpendicularly: this rule applies to all such punctures, and it is proper that I should point out its importance. If the bistoury traverses the textures obliquely, it will have to pass through a greater extent of them, and hence, consequently, there is more pain; hence, also, the exit of the matter is less free, and probably we may have infiltration of the surrounding parts in consequence. Besides, in abscess on the parietes of the abdomen, there may be a hernia without any indication directing our attention to it. I was called by Dr. Piorry to a woman who had received a kick on the belly, in consequence of which an abscess had formed there. The patient was carefully interrogated, and assured us that she had never suffered from any symptom connected with the digestive organs,—there

had never been anything indicative of hernia. However, I opened the abscess cautiously, when a gush of purulent matter escaped, and I then saw that there was a knuckle of intestine floating in the tumour. What would have happened had I thrust the instrument into the tumour with that degree of *brusquerie* which some affect on all occasions?

An abscess deep in the parietes of the chest or abdomen may be actually in contact with the pleura or peritoneum, while that in the neighbourhood of a joint may reach to the capsular ligament. If, then, you open abscesses of this nature with no more precaution than what is generally adopted—and especially if the muscular contraction prevents you from judging when you have passed from the more into the less resisting part—or, if the abscess be not entirely filled, I repeat, that under such circumstances you incur the risk of penetrating the pleura or peritoneum. It is therefore imperiously necessary to open the abscess as carefully as if it were a hernial sac.

I must not forget to add, that in proportion as the incision is made, the forefinger being introduced into it, enables us the better to appreciate the depth at which the collection of matter is situated. I know that this is painful to the patient, but the suffering is not of a nature to have any effect upon his health, and we must above all attend to his safety.

If the abscess be in the course of a large nerve or artery, you are told to make the incision so as to avoid it. But the tumefaction and induration of the parts are such, that you cannot recognise their relative situation; and although anatomy tells us the natural situation of the vessels, yet the development of an abscess often changes the relative position of the surrounding parts. If the artery and nerve in question always retained their wonted place, there would be no difficulty; but, as I have said, they are frequently displaced, and if you cannot ascertain their new position, what are you to do? Certainly, not to imitate those practitioners who, in order to conceal their embarrassment, declare the abscess to be not yet mature, and so postpone opening it. This delay may be attended with the worst consequences. If, for instance, an abscess be situated in the neck, near the carotid artery, the jugular vein, or the eighth pair of nerves, or great sympathetic, in the midst of the fine loose tissue of that region, the matter may find its way into the chest, or, according to Desault, even into the abdomen. It is, therefore, urgently necessary to open all such abscesses very promptly, and it is now twenty years since I have adopted this method. Take the neck as an example: I there make an incision parallel to its axis, and which divides layer by layer successively the skin, the cellular membrane, and, if necessary, the superficial aponeurosis. I next take a blunt probe, and limit the extent to which it is to penetrate the textures, by holding it between the thumb and forefinger. I then introduce this to the bottom of my incision, and make it pass on by separating or rather pushing aside, the fibres of the parts beneath. Whenever the instrument has entered the abscess, there is a cessation of resistance, besides which I perceive drops of pus oozing along the sides of the instrument. I then push it upwards and downwards, so as to enlarge the opening, and thus the matter finds a ready exit.

Such is the result of twenty years' experience, and I have never yet met with any accident from hemorrhage; I am therefore inclined to believe that those surgeons, otherwise very able, in whose hands such occurrences have taken place, have either been ignorant of, or neglected, the precautions here laid down.—*Gazette des Hôpitaux*.

38. *Treatment of Hydrocele by injections of Iodine*.—In our preceding No. p. 508, we noticed the employment by M. Velpeau, of a solution of iodine, as an injection for the cure of hydrocele. He appears, however, to have been anticipated in the use of this remedy, by Mr. J. R. MARTIN. This last named gentleman in a paper communicated to the Medical and Physical Society of Calcutta, in Jan. 1835, and published in the seventh volume of their Transactions, states that he had up to the time of presenting his paper, treated upwards of ninety cases with the iodine injection, without danger or inconvenience. In only one case did he observe symptoms of a dangerous tendency to supervene; and, as it even tends to confirm the safety of the operation, it may be worthy of mention. "It was that (says Mr. Martin) of a Mahomedan labourer, who went about his occupations

for fourteen days after the operation, and came into the hospital on the fifteenth, with a highly-inflamed and shining scrotum. A few leeches, an evaporating lotion, and a purgative, prevented any accident. Finding the proportions in the injection at first used, to answer so well, (a solution of tincture of iodine, in the proportion of two drachms to six of water, of the ordinary temperature,) I have never altered them; nor need there, perhaps, be any change, even when Europeans are the subjects of operation. In the case of a few robust Mahomedans, who use animal food, but one common urethra-syringe full was injected, and that quantity may be found sufficient in the cases of most Europeans.

"The effects of the iodine solution seem to be immediate, the inflammation arriving at its height in about twenty-four hours, and after that subsiding rapidly. In only two instances has bleeding by leeches been found necessary. Poultices, cold lotions, and purgatives, have generally constituted the treatment; and even these have not been had recourse to in a large proportion of cases.

"Twelve cases of double hydrocele, treated on both sides at once, recovered with quite as much ease and expedition as the single cases. In one of these cases a much larger quantity than had before been tried was injected with safety; but if there be any superiority in the iodine injection, as used by me, it consists in the smallness of the quantity used, and its being retained; for, in the hands of the best surgeons, infiltration may and does very frequently happen with the port wine solution, owing, as I conceive, to the cremaster muscle, excited by pain, drawing the cavity of the sac off the end of the canula.

"The only caution that appears to me to be necessary in the performance of the injection with iodine, is to see that the syringe is in good order, that the piston fits well; otherwise air will be injected, and the operator deceived as to the quantity of fluid used."

In the *Indian Journal of Medicine* for May, 1836, two cases are also related by Dr. STEWART, successfully treated at the Calcutta General Hospital, with injections of iodine.

39. *Ligature of the Arteria Innominate*.—This operation has been performed by Mr. LIZARS for aneurism of the subclavian artery. The patient died twenty-one days after the operation. We shall give the details of the case in our next number.

MIDWIFERY.

40. *Administration of the Ergot of Rye in anticipation of Uterine Hemorrhage*.—The *Lancet* of the 15th of April last, contains some observations from Mr. BRADLEY, on his successful administration of the ergot of rye in a case of uterine hemorrhage, immediately succeeding the expulsion of the child, which he concludes by asking whether, when such an unfortunate event is apprehended, it might not be prevented altogether, by giving the ergot immediately before the birth of the child?

In the subsequent No. of the same Journal, (April 22,) T. ABRAHAM, Esq. bears testimony to the successful administration of the remedy under the circumstances indicated, in six cases; and J. KISCH, Esq., states that he has been accustomed for some time past, to exhibit the ergot in similar cases, and with the most happy results. So satisfied is this last practitioner of the powers of the ergot in preventing uterine hemorrhage, that he invariably inquires, he states, whether the patient has been in the habit of flooding after delivery, and if so of using the ergot as suggested by Mr. Bradley.

The utility of this practice is unquestionable; but if it has any novelty on the other side of the Atlantic, as we suppose it has from the stress laid upon it in the communications just noticed, it certainly possesses no claim to such distinction here. This practice is pointed out by Dr. Stearns of New York, in his pamphlet on the Ergot, published upwards of 15 years ago, (see *Philada. Journ. Med. and Phys. Sc.*, Vol. V. p. 44), and was employed many years since, by our venerable and esteemed friend Dr. Dewees, and is distinctly and strongly recommended by him in his valuable system of midwifery.